

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01798

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf, Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HOMER</u> First <u>WAYNE</u> Middle <u>CHAPMAN</u> Last		4. DATE OF DEATH <u>FEB.</u> Month <u>8</u> Day <u>1959</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-54</u>
9. AGE (in years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alton E. Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Toye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alton E. Chapman</u>		Address <u>Rt. #1 Bx 123 G Brandywine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fluid and Electrolyte Imbalance</u> 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Gastroenteritis</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>DEATH</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury - vomiting, diarrhea, &amp; fever for 2 weeks</u>	
20c. TIME OF DEATH Hour <u>7:30</u> P.M. <u>FEB. 8</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>No injury</u>		20f. (City or town) (County) (State) <u>Malcolm, Charles, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR M.D.</u>		DATE SIGNED <u>2/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE  
DEATH CERTIFICATE

WISCONSIN STATE DEPARTMENT OF HEALTH - BURLINGAME 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1934

Wesley R. Ross  
Wesley R. Ross

Wesley R. Ross

Age

Sex

Color

Height

Weight

Build

Complexion

Hair

Eyes

Mouth

Nostrils

Ears

Throat

Lungs

Heart

Stomach

Intestines

Genitals

Skull

Brain

Spinal Cord

Nerves

Muscles

Bones

Teeth

Salivary Glands

Thyroid Gland

Parathyroid Glands

Pituitary Gland

Adrenal Glands

Pancreas

Spleen

Liver

Gallbladder

Bile Duct

Bladder

Uterus

Vagina

Rectum

Sigmoid Colon

Cecum

Appendix

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Items 7,8,9,14 Film G239 2-20-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles County, MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hilltop, Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hilltop</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hilltop Md (Rural)</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>SARAH</i> First Middle Last <i>CUNNINGHAM</i>		4. DATE OF DEATH <i>FEB. 12 1959</i> Month Day Year	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>COL.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 14, 1887</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Brown</i>		14. MOTHER'S MAIDEN NAME (First name unknown) <i>Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Moses Cunningham</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> <i>331X</i> DUE TO (b) <i>Hypertension and Generalized</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>22 1/2 hrs.</i> <i>years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>NONE</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>SPONTANEOUS - occurred at home</i>	
20c. TIME OF INJURY Month, Day, Year <i>Hour 7:30 a.m. 2-11 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HOME</i>	20f. (City or town) (County) (State) <i>Riverside, Charles, Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V. B. Detton</i>		DATE SIGNED <i>2/12/59</i>	
EXAMINER'S NAME (Type) <i>V. B. DETTOR, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/15/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Hilltop, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson &amp; Jenkins</i>		24a. REC'D BY REGISTRAR <i>4804 G. Ave. Md</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1796

## CERTIFICATE OF DEATH

Reg. Dist. No.

01800

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUGHESVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 YR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SIDNEY</u> Middle <u>CATHERINE</u> Last <u>ESTEP</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1864</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Toye</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Edelen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Henry Estep, Bryantown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIO-SCLEROSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 YEARS</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>07</u> , to <u>FEBRUARY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEBRUARY 19</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John H. Griffin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1797

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01801

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>CHARLES</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>CHARLES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Residence</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>WILLIAM THOMAS HENDLEY SR.</i>		4. DATE OF DEATH Month <i>FEB</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Potomac, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Hendley</i>		14. MOTHER'S MAIDEN NAME <i>Martha Kaywood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>William T. Hendley Jr.</i>		Address <i>5110 St. Barnabas Rd., Temple Hills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac dilatation</i> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>instant.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-11</i> , 19 <i>59</i> , to <i>2-12</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-11</i> , 19 <i>59</i> , and that death occurred at <i>8:40 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) <i>LA PLATA, MD.</i> DATE SIGNED <i>2-12-59</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>		Aa	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Feb. 14, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Barnabas Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Temple Hills, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. CHAMBERS CO.</i>		24a. REC'D BY REGISTRAR <i>577 11th St SE Wash., D.C.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1798

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tompkinsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hill</b>				4. DATE OF DEATH Month Day Year <b>Feb 9 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-59</b>		9. AGE (In years last birthday) yrs. Months Days Hours Min <b>15 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bruce Hill</b>				14. MOTHER'S MAIDEN NAME <b>Mary Celestine Chisley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mary C. <del>Stark</del> Hill, Tompkinsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Permaternity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>75 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Body weighed 11lb 3oz. -</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-8</b> , 19 <b>59</b> to <b>2-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-9</b> , 19 <b>59</b> , and that death occurred at <b>3:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. M. Johnson</b> M.D.				ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>		DATE SIGNED <b>2-9-59</b>	
PHYSICIAN'S NAME (Type) <b>F. M. Johnson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Issuu Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Bruce Hill (Father)</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 18 59</b>		24b. REGISTRAR'S SIGNATURE <b>Christina E. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066305XVO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

010000

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John Bruce Pitt

100-443887-118A

DOI: 10.1002/for



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11803

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grayton (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Baily</b> Last <b>Kendrick</b>		4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 20, 1893</b>
9. AGE (in years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b>	
11. IF UNDER 24 HRS. Hours <b>59</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Kendrick</b>		14. MOTHER'S MAIDEN NAME <b>Katy M. Flowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-38-5912</b>	
17. INFORMANT <b>Mr. Robert C. Kendrick (Son)</b>		Address <b>Nanjemoy, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2-3-59</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3-59</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Bladensburg, Maryland</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>F. J. EDELEN</b>		DATE SIGNED <b>2-4-59</b>	
EXAMINER'S NAME (Type) <b>F. J. EDELEN</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/6.1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC., LA PLATA, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Kious</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF HEALTH - BIRTH AND DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Time of Death	
Place of Birth		Place of Death		Cause of Death	
Occupation		Manner of Death		Signature of Medical Examiner	
Residence		Hospital or Institution		Date of Report	
Medical History		Physical Examination		Laboratory Examinations	
Social History		Mental Examination		Autopsy	
Family History		Previous Illnesses		Postmortem Findings	
Vital Statistics		Death Certificate		Burial Record	
Funeral Home		Burial Place		Remarks	

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01804

Reg. Dist. No.....

1800

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>West Virginia</u> COUNTY <u>Harrison</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LaPlata Md</u>		LENGTH OF STAY (in this place) <u>14-Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salem</u>		<u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hosp. LaPlata Md</u>				STREET ADDRESS <u>278-W-Main</u> (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Everett Ainsley Luzader</u>				<b>4. DATE OF DEATH</b> <u>2-25-59</u>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>W-US</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>3-2-1884</u>	<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher-Rt.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Auburn-W. VA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>Winfield Scott Luzader</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Davis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>232-24-1732</u>		<b>17. INFORMANT'S ADDRESS</b> <u>St. Albans West Virginia. (Son)</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>200.1</u> IMMEDIATE CAUSE (A) <u>General Circulatory Collapse</u>						<u>2-Hrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Lympho-Sarcoma Mesenterary Lymph Glands</u>						<u>2-Yrs</u>	
(C) <u>Generalised Metastases-Abdominal</u>						<u>2-Yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>12-22-57</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Generalised Lympho-Sarcoma of the mesenterary Lymph Glands</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-10-58</u> , 19....., <b>to</b> <u>2-25-59</u> , 19....., <b>that I last saw the deceased</b> <u>alive on</u> <u>2-25-59</u> , 19....., <b>and that death occurred at</b> <u>10-45P</u> .M, <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Everett Ainsley Luzader</u> M.D.				<b>DATE SIGNED</b> <u>Indian Head Md</u> <u>2-26-59</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2/26/59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Harrisonville</u>		<b>LOCATION (City, town, or county) (State)</b> <u>West Virginia</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 2 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Charles L. Howard</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wickert Inc LaPlata Md</u>			



THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY HIM AND RETURNED TO THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND. IT IS TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND. IT IS TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND. IT IS TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT OF THE STATE OF MARYLAND.

# CERTIFICATE OF DEATH

800

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1921

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF CLERK

12. SIGNATURE OF JUDGE

13. SIGNATURE OF SHERIFF

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

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44. SIGNATURE OF JURY

45. SIGNATURE OF JURY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01805

1801

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Old</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welcome</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welcome</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Marie</u> Middle <u></u> Last <u>Nelson</u>				<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Not known (about 70 yrs)</u>	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Brentland, Old.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brentland, Old.</u>	
13. FATHER'S NAME <u>Willie Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elizabeth Riley, Welcome, Old</u> Address <u></u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease with Congestive Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Feb 24, 1959</u> to <u>Feb 21, 1959</u> , that I last saw the deceased alive on <u>Feb 9, 1959</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.				ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>2/21/59</u>			
PHYSICIAN'S NAME (Type) <u>Frank A Susan M.D.</u>				<u>Indian Head, Old</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/25/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hill Top Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON JENINS</u> ADDRESS <u>4804 Ma. Ave NW</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

1802

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fenwick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>DORTHY</b> Last <b>PIERCE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard P. Ennis</b>				14. MOTHER'S MAIDEN NAME <b>Mary ( ? )</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mr. Harry Pierce (Son) Fenwick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBROSCLEROSIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-26-1958</b> to <b>2-11-1959</b> , that I last saw the deceased alive on <b>2-9-1959</b> , and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Chen</b>				ADDRESS (Street, city or town, state) <b>2-11-59</b>			
PHYSICIAN'S NAME (Type) <b>PAUL CHEN, M.D.</b>				DATE SIGNED <b>ACCKEEK, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13 / 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bumpy Oak Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pomonky, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC. * LA PLATA, MD.</b>				24a. REC'D BY REGISTRAR <b>FEB 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinnel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

292



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01807

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Warysburg</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Warysburg</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>LARRY ROVEY POSEY</i>		4. DATE OF DEATH Month <i>2</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-30-18</i>
9. AGE (In years last birthday) <i>40</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>26</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sanitary (Wary.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>
13. FATHER'S NAME <i>Archie Posey</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Spinos</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Archie Posey (Father)</i>		Address <i>Warysburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>056.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Whooping cough</i> (c) <i>Whooping cough</i> DUE TO cause last.			INTERVAL BETWEEN ONLY AND DEATH <i>2-24-59</i> <i>2-4-59</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/27/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mount Hope Baptist</i>	22d. LOCATION (City, town, or county) (State) <i>Warysburg</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Lee Topola</i>		ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i>2-26-59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE  
OFFICE OF  
THE  
MEDICAL  
EXAMINER  
OF  
THE  
STATE  
OF  
MARYLAND

DEATH

LOCAL HEALTH  
OFFICIAL

NAME OF  
DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

HEIGHT

WEIGHT

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATION

COLORED DISC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1804

## CERTIFICATE OF DEATH

Reg. Dist. No.

01808

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicans Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WASHINGTON</u> Last <u>SIDLER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sidler</u>		14. MOTHER'S MAIDEN NAME <u>Alice Welsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>R.F.D. 1 Cecokeek, Maryland</u> <u>Mrs. Mary L. Sidler (Daughter-in-law)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Malnutrition</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No injury</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>no injury</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no injury</u>
20f. (City or town) <u>no injury</u>		(County) (State)	
21. I certify that I attended the deceased from <u>FEB. 1, 19 59</u> , to <u>FEB. 7, 19 59</u> , that I last saw the deceased alive on <u>FEB. 7, 19 59</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. B. Dettor</u>		DATE SIGNED <u>February 8, 1959</u>	
PHYSICIAN'S NAME (Type) <u>V. B. Dettor, M.D.</u>		<u>La Plata, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/9/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nanjenoy Baptist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nanjenoy, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>AREHART FUNERAL HOME, INC.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

108

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1805

CERTIFICATE OF DEATH

11809

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Nanjemoy</b>		c. LENGTH OF STAY IN 1b <b>Rural Nanjemoy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>May</b> Last <b>STICKEL</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>US-W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 24 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S M maiden NAME <b>UNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>William H. STICKEL, Nanjemoy Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>482X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastrointestinal lesion</b> DUE TO <b>INFLUENZA</b> (c) <b>INFLUENZA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>3 days</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease and diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>28 Feb</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>28 Feb</b> , 19 <b>59</b> , and that death occurred at <b>9:35 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata</b> DATE SIGNED <b>1 Mar 59</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		<b>Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>March 3 1959</b>	<b>Riverview Cem.</b>	<b>Williamsport, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01810

1806

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Physicians Mem. Hospital</b>				f. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>STUNNED</b> Middle <b>Rupert J. Strickland, Jr.</b> Lost				4. DATE OF DEATH <b>FEB.</b> Month <b>2</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 23, 1947</b>	
				9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rupert Strickland</b>				14. MOTHER'S MAIDEN NAME <b>Stella W. Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Russell Causby (Step-Father) - La Plata, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>812X</b> DUE TO <b>Cerebral Concussion and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Probable Cerebral Laceration</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>20 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by school bus on Rt. 301</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>3:10 p.m.</b> <b>2-2-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 301</b>		20f. (City or town) (County) (State) <b>LA PLATA, CHARLES, MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>V. B. DETTOR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-2-59</b>			
EXAMINER'S NAME (Type) <b>V. B. DETTOR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Full Gospel Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cederville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>AREHART FUNERAL HOME, INC. * LA PLATA, MD.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR FILL  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH

AGE  
SEX  
RACE  
DATE OF BIRTH

PLACE OF BIRTH  
MARRIED  
OCCUPATION

EDUCATION  
RELIGION  
MILITARY SERVICE

PREVIOUS ILLNESS  
CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH  
MANNER OF DEATH

ORGAN OR SYSTEM INVOLVED  
NATURE OF LESION

ANATOMICAL DIAGNOSIS  
HISTOLOGICAL FINDINGS

TOPOGRAPHICAL FINDINGS  
GROSS FINDINGS

MICROSCOPIC FINDINGS  
IMMUNOHISTOCHEMISTRY

IMMUNOPATHOLOGY  
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FOR STATE  
HEALTH DEPT.

PLACE OF BIRTH  
DATE OF BIRTH

CHARLES

NAME

DATE OF BIRTH

DATE

TIME

PLACE

DATE OF BIRTH

TIME

PLACE

DATE OF BIRTH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01812

Reg. Dist. No.

1808

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRYANTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Bryantown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NONE</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>GRANT LEE THOMAS</b>		4. DATE OF DEATH <b>FEBRUARY 20 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 7 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	
11. BIRTH PLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wade</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-16-24934</b>	
17. INFORMANT <b>Grace Thomas, Bryantown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 min years</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Accused while walking down street</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 p.m. 2-20 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Bryantown, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V.B. Dettor</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01813

1809

Item 1 Film G239 2-25-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Plains Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PATRICIA ANN THOMPSON</u>		4. DATE OF DEATH <u>2</u> Month <u>17</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-22</u>
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MAXWELL FRANCIS THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNE THERESA PROCTOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Ann T. Thompson, White Plains, Md.</u>		Address <u>White Plains, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>TRAUMA Concussion</u> (c) <u>HIT BY AUTO</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2-17-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>HIT BY AUTO ON HIGHWAY</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-17-59</u> o. m. <u>8:00</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>POMFRET CHAS MD.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDLEN</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDLEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-19-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or county) <u>Pomfret, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "John Doe"]

2. SEX: [Faint text, possibly "Male"]

3. AGE: [Faint text, possibly "45"]

4. RACE: [Faint text, possibly "White"]

5. DATE OF DEATH: [Faint text, possibly "10/15/1918"]

6. PLACE OF DEATH: [Faint text, possibly "Home"]

7. CAUSE OF DEATH: [Faint text, possibly "Pneumonia"]

8. MANNER OF DEATH: [Faint text, possibly "Natural"]

9. SIGNATURE OF EXAMINER: [Faint signature]

10. OFFICE OF EXAMINER: [Faint text, possibly "Baltimore, Md."]

11. COUNTY OF DEATH: [Faint text, possibly "Baltimore"]

12. DISTRICT OF DEATH: [Faint text, possibly "City of Baltimore"]

13. NAME OF DECEASED: [Faint text, possibly "John Doe"]

14. SEX: [Faint text, possibly "Male"]

15. AGE: [Faint text, possibly "45"]

16. RACE: [Faint text, possibly "White"]

17. DATE OF DEATH: [Faint text, possibly "10/15/1918"]

18. PLACE OF DEATH: [Faint text, possibly "Home"]

19. CAUSE OF DEATH: [Faint text, possibly "Pneumonia"]

20. MANNER OF DEATH: [Faint text, possibly "Natural"]

21. SIGNATURE OF EXAMINER: [Faint signature]

22. OFFICE OF EXAMINER: [Faint text, possibly "Baltimore, Md."]

23. COUNTY OF DEATH: [Faint text, possibly "Baltimore"]

24. DISTRICT OF DEATH: [Faint text, possibly "City of Baltimore"]

25. NAME OF DECEASED: [Faint text, possibly "John Doe"]

26. SEX: [Faint text, possibly "Male"]

27. AGE: [Faint text, possibly "45"]

28. RACE: [Faint text, possibly "White"]

29. DATE OF DEATH: [Faint text, possibly "10/15/1918"]

30. PLACE OF DEATH: [Faint text, possibly "Home"]

31. CAUSE OF DEATH: [Faint text, possibly "Pneumonia"]

32. MANNER OF DEATH: [Faint text, possibly "Natural"]

33. SIGNATURE OF EXAMINER: [Faint signature]

34. OFFICE OF EXAMINER: [Faint text, possibly "Baltimore, Md."]

35. COUNTY OF DEATH: [Faint text, possibly "Baltimore"]

36. DISTRICT OF DEATH: [Faint text, possibly "City of Baltimore"]

# CERTIFICATE OF DEATH

Reg. Dist. No.

1810

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution after admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Port (rural)</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Port</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Pearl Tippet</b>			First Middle Last		4. DATE OF DEATH Month Day Year <b>Feb. 17 1959</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6 1900</b>	
9. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>store operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>grocery store</b>		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Preston Tippet</b>				14. MOTHER'S MAIDEN NAME <b>Geneva Thompson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217 32 1992</b>		17. INFORMANT Address <b>Mrs. Edith Tippet, New Port, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma to right lung</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the larynx</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>4 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>No injury</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>No injury</b>		20f. (City or town) (County) (State) <b>Newport, Charles, Md.</b>	
21. I certify that I attended the deceased from <b>2-15</b> , 19 <b>59</b> , to <b>2-15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-15</b> , 19 <b>59</b> , and that death occurred at <b>3</b> <b>P.</b> M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>V.B. Dettor</b> M.D. <b>Box 397, LA PLATA</b> DATE SIGNED <b>2/17/59</b> PHYSICIAN'S NAME (Type) <b>V.B. DETTOR, M.D.</b> <b>MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2-19-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Port, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG259 2-20-59 et

1811

CERTIFICATE OF DEATH

01815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Victoria</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt Victoria</b>	
		d. STREET ADDRESS <b>1</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PHIL</b> Middle <b>MAYNARD</b> Last <b>WELLS</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1898</b>
9. AGE (In years last birthday) <b>59 60 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Residence</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phil Wells</b>		14. MOTHER'S MAIDEN NAME <b>Ida Lyles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mosher Wells, Mt Victoria, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March, 1958</b> to <b>11 Feb., 1959</b> , that I last saw the deceased alive on <b>26 Dec., 1958</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2-14-59</b>			
ACTUAL SIGNATURE <b>Frederick M. Johnson, M.D.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Frederick M. Johnson, M.D.</b>		<b>La Plata, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shiloh M.E.</b>	22d. LOCATION (City, town, or county) (State) <b>Newburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>		ADDRESS <b>24a. REC'D BY REGISTRAR DATE FEB 17 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

## CERTIFICATE OF DEATH

01816

Reg. Dist. No.

1812

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Pomfret.</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>Rosalie Willett.</b>				4. DATE OF DEATH <b>February 8 1959.</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1882</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Winkler</b>				14. MOTHER'S MAIDEN NAME <b>Emily Adams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Lee Willett, Pomfret Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral vascular accident.</b> DUE TO (c) <b>Hypertensive heart disease, congestive failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>3 months</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>April</b> , 1950, to <b>7 Feb</b> , 1959, that I last saw the deceased alive on <b>7 Feb</b> , 1959, and that death occurred at <b>12:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Feb 59</b> DATE SIGNED <b>8 Feb 59</b>							
ACTUAL SIGNATURE <b>Arthur O. Woody, MD</b>		SIGNATURE <b>James Wood Clinic</b>					
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		La Plata, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Josephs</b>	22d. LOCATION (City, town, or county) (State) <b>Pomfret Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hutt Funeral Home, Waldorf, Md.</b>			24a. REC'D BY REGISTRAR <b>FEB 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur O. Woody</b>		

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